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ABSTRACT

This document discusses and reviews the research on the issue of in females and males. A 1970 study by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel found that both male and female clinicians ascribed more positive characteristics to males and fewer desirable traits to females. Research disagreeing with this position and failing to replicate the study is cited. Other research showing that clinicians tended to reject female patients who exhibited masculine traits such as assertiveness is cited as support for Broverman. Two theories, the labeling theory, and the higher male social status theory which account for possible bias are discussed. Several studies relating disorders to male and female gender type expectations are reviewed. It is concluded that females are judged as maladjusted when exhibiting gender role incongruent behavior. The issue of an androgyny concept to counteract sex stereotyping is also reviewed. A reference list is included. (ABL)

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On Gender Roles and Perception of Maladjustment

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RUNNING HEAD: Perception of Maladjustment

Abstract

Background and selected research evidence are summarized with regard to the question of different standards of male and female "mental health." Recent studies, specifically concerning the effects of gender role-incongruent behaviour on the perception of maladjustment, are outlined. These studies provide evidence supporting the classic study of Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel (1970), in which a double standard of male versus female mental health was alleged.

On Gender Roles and Perception of Maladjustment

In the last decade, interest has been drawn increasingly to the question of whether a different or "double" standard is used by clinicians to assess maladjustment in a male versus a female "target" person. A clear sign of such interest has of course been the existence of task forces, within both the Canadian and American Psychological Associations, with which to investigate sexist practices in psychology.

The allegation of a double standard, in which a dispositional trait or characteristic is seen as positive for males but less so for females, traces directly to the provocative and oft-cited study by Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, (1970; see also Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972). Broverman et al., using an adjective check-list procedure, found that both male and female clinicians ascribed more positive characteristics to males, described the normal, healthy adult as highly similar to the normal, healthy male, and also saw less desirable traits as typical of the normal, healthy female. Such a female, for example, was seen as more submissive, less independent, less adventurous, less competitive, more easily excited in a minor crisis, more emotional, less objective, and more easily influenced than the normal, healthy male. It has been noted that, in fact, such a portrayal resembles the symptoms of the hysterical, or masochistic, personality (Belote, 1976) and that even if females refuse to conform to the above characteristics of the normal, healthy female, they still run the risk of being labeled negatively, e.g., as "castrating," or otherwise maladjusted (Tennov, 1976). Although the Broverman research has been discussed objectively in recent volumes on the psychology of women (e.g., Greenglass, 1982; Hyde, 1985) its results continue frequently to be emphasized

and interpreted as illustrating "the male sex bias" (e.g., Atwater, 1983). As Chesler (1973) states, "The Broverman study shows that for a woman to be healthy she must 'adjust' to and accept the behavioral norms for her sex even though these kinds of behavior are generally regarded as less socially desirable" (p. 69). From this position, Chesler and others have argued that female clients in psychotherapy should be treated by female rather than male therapists. Schaef (1981) has eloquently articulated the view that life events happening to males are seen as more important than events involving females. Kaplan (1983) has argued further that the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III) contains "masculine-biased assumptions about what behaviors are healthy and what behaviors are crazy" (p.788), with behaviours taken to represent emotional disturbance in females going relatively unnoticed or seen as insignificant when found in males. In addition, Stark-Adamec (1981) has provided evidence that research funding within the mental health establishment is not representative of female issues and mental health problems.

Gender Role Incongruence

The Broverman et al. research, despite its high frequency of supportive citations in abnormal and social psychology texts, as well as in the popular literature, has been criticized on several grounds. Clinicians describing the healthy adult for example, may have assumed, albeit in sexist fashion, that this concept referred to a male, thus distorting the resulting ratings. Other criticisms (see Greenglass, 1982) have pointed out the vintage of the research, the transparency and artificiality of "analogue" studies, and the possibility that changes have now occurred in professionals' perceptions of male and female mental health. Moreover, in a similar study, Gomes and

Abramowitz (1976) found no evidence of anti-female bias when clinicians were asked to rate the extent of mental illness indicated in case history descriptions differing only in the sex of the patient described. The most serious drawback to the Broverman et al. research has of course been that it did not and cannot address directly the question of whether clinicians in fact display sexist or discriminatory behaviour in actual therapeutic interactions with clients or in other mental health practices (Doyle, 1985; Stark-Adamec, Graham, & Pyke, 1980; Toukmanian, 1985). Amid the controversy elicited by the Broverman work, however, the research of Doherty and colleagues has indeed provided supportive evidence in this latter sphere. Doherty (1976, 1978) observed that professional clinicians in a psychiatric hospital setting tended to reject female patients who showed stereotypically masculine traits such as assertiveness, or other behaviours incongruent with traditional female sex role expectations. Furthermore, female patients seemingly violating the Broverman et al. profile of the "healthy" woman remained in hospital longer and were seen as more seriously disturbed. Unlike male patients, discharge for female patients was not related to judged degree of psychopathology, but was related to demographic, sex role-related factors such as employment and marital status. In any event, the aftermath of the Broverman research has tended to focus, somewhat speculatively, on rather general issues such as feminist therapy, sexual contact between patients and therapists, and sexism in psychotherapy. Chapter 18 in Rohrbaugh's (1979) book Women: Psychology's puzzle, for example, is entitled "Are Women Sicker Than Men?" To date, however, although there is greater concern with such issues, we still have insufficient research evidence concerning differential perceptions of male and female adjustment (see Hyde, 1985).

Two general perspectives, apart from the Broverman et al. research, have developed in regard to such perceptions. For example, labeling theory (e.g., Goffman, 1961; Scheff, 1966) holds basically that persons of lower societal status become stigmatized generally, and forever carry such stigma with them as a "master status." From this position, (see also Chesler, 1973) undesirable behaviour in females is said to be viewed more negatively than for males. Another perspective (Rushing, 1979; Tudor, Tudor, & Gove, 1977) holds essentially that since men generally hold higher status and more influential positions in society, undesirable or nonconforming behaviour in males, being more visible or threatening, should thus be seen more negatively than for females. A major difficulty with such positions, as well as with a position which emphasizes a generalized anti-female bias, is that they overlook the content of prevailing gender role stereotypes, the existence of specific expectations associated with them, and the effects, for males as well as females, of whether or not a "sick" behaviour is congruent with the wider gender role expectations appropriate to the sex of the person involved. Instances of substance abuse, aggressive, or antisocial personality disorders, for example, would be essentially congruent with the prevailing male gender role stereotype. Cases of neurosis, anxiety, or depression would be more congruent with the female stereotype. Using these classifications, Rosenfield (1982) analyzed data from 666 psychiatric emergency room patients in a large municipal hospital. All common diagnostic categories were well represented in her sample. Using analyses of covariance, controlling statistically both for the type of diagnosis and level of disturbance (e.g., psychotic versus neurotic categories), Rosenfield found no overall tendency for either sex to be reacted to (i.e., hospitalized, whether voluntarily or involuntarily) more

severely than the other. However, the likelihood of hospitalization was highly related to whether or not the client's behaviour was congruent with prevailing gender role stereotypes. Males were significantly more likely to be hospitalized for "feminine" symptoms such as anxiety or depression, whereas females were significantly more likely to be hospitalized in cases involving antisocial disorder or substance abuse. This supports the view that behaviour incongruent with gender role expectations is viewed as more problematic and as requiring more drastic treatment measures, though it does not support the position of Tudor et al. (1977), mentioned previously, that reactions to unusual behaviour should be more severe in the case of male patients. Cultural role stereotypes thus appeared to affect the perception and disposition of these patients, in terms of "appropriate" versus "inappropriate" ways for males and females to express behavioural or emotional deviation.

Four studies, recently conducted at the University of Windsor, have provided additional information in essential support of Rosenfield's results. In the first study (Waisberg, 1984), case history descriptions of four fictional clients were judged on various aspects of their perceived seriousness and degree of severity, by a sample of 83 professional psychologists, all registered in the province of Ontario. The histories were constructed from symptoms taken from the relevant DSM-III descriptions. Two histories described symptoms congruent with the female gender role stereotype, i.e., Major Depression and Generalized Anxiety Disorder, and two were congruent with the male stereotype, i.e., Antisocial Personality Disorder and Alcohol Abuse. For half of the respondents, the case histories referred to a male and, for half, to a female person. Waisberg found that, overall, female

patients were not seen as more disturbed than males. She did find, however, a significant interaction between sex of the patient described and the type of symptoms involved. Depressed and anxious males were seen as much more severely disturbed than were females with the same symptomatology. Also, antisocial and alcohol-abusing females were seen as significantly more disturbed than were their male counterparts. Simple effects tests within this interaction showed further that it was the "feminine" disorders of Depression and Generalized Anxiety Disorder for which the largest sex of patient differences in perceived level of disturbance occurred. That is, it was seen as much worse for a male to display feminine symptoms than for a female to display masculine-typed symptoms. The two masculine-typed disorders were also rated as significantly more serious problems than either Major Depression or Generalized Anxiety Disorder. Interestingly, the male psychologists, overall, were significantly more positive about the usefulness of psychotropic drugs as treatment, and recommended them significantly more frequently, even though female psychologists predicted significantly more optimistic outcomes for treatment in general. Depression, specifically, was seen by both male and female psychologists as significantly more serious when shown by a male, as compared to a female showing the same symptomatology. Using large samples of undergraduate subjects as well, Waisberg found that significantly more intensive treatment measures were recommended for depressed males than for depressed females; also, more intensive treatment was recommended for Alcohol Abuse and Antisocial Personality Disorders, i.e., if the patient was female. Waisberg also found that, overall, male patients were seen as more seriously ill than were female patients with identical symptomatology.

In the second study (DeRose & Page, 1985), attitudes of professionals and

lay persons toward male and female suicide were studied, using the 100-item Suicide Opinion Questionnaire (Domino, Moore, Westlake, & Gibson, 1982). Forty-eight registered social workers, 38 registered psychologists, 45 registered nurses, and 42 nonprofessionals, served as subjects. The SOQ was developed by Domino et al. after an intensive survey of the suicide literature, and contains several item clusters concerning both factual and attitudinal aspects of suicide, e.g., its moral acceptability, symptomatology, personal and environmental causation, and relationship to religion and mental illness. In this study, however, half of the subjects received an SOQ in which the items referred to a female (e.g., "Suicide seems more natural in women") with the other half receiving a corresponding "male" version. For each item (statement), the degree of subject agreement was requested, using 5-point Likert scales. Both multivatiate and univariate analyses of variance on SOQ items indicated that sex of the target person significantly affected judgements about the acceptability, nature, and etiology of suicide. Forty-six univariate analyses, for example, showed such effects. The same behaviours (e.g., depression, crying, or making an actual suicide attempt) were generally perceived by both the professional and lay groups as less serious, and less in need of serious attention or intervention by professionals, when described as occurring in a female. Analyses of significant items and item groups showed that suicide was seen as a more frequently expected, in effect less catastrophic, option for females than for males. Two other recent studies have also found that while traditionally feminine characteristics in children are seen by teachers as attractive, traditionally male characteristics are seen as more valuable and more important in life (Page & Lafreniere, in press; Schneider & Coutts, 1980).

In the third study (Page & Yee, 1985), a total of 148 undergraduate subjects, tested in three separate groups, used the 41 Likert scale adjectives (those used originally by Broverman et al., 1970) with which to construct personality profiles of two homosexual stereotypes, i.e., the "lesbian," and "male homosexual," as well as of the "normal, healthy adult." Analyses and comparisons of the resulting profiles showed that both male homosexuals and lesbians were portrayed quite unfavourably, by both male and female subjects, as compared to the healthy adult. Additional data from 75 subjects were gathered in which subjects, again using the Broverman scales, profiled the "homosexual adult." Profiles of the "homosexual adult" and "homosexual male" were essentially identical. In general, the results again supported the role of a particular gender role nonconformity, i.e., homosexuality, as a factor in the perception of maladjustment. It did appear, however, that such was viewed as more serious when shown by a male target person. In another relevant study, Buczek (1981) found that professional counsellors, listening to tape recordings of male and female clients, afterward could recall fewer counselling concerns expressed by female than by male clients. Buczek's results, in reference to the female client, have been described as meaning that "she just wasn't remembered as well" (Hyde, 1985).

In the fourth study (Page, in press) archival data, from the civil commitment certificates of 84 (42 male, 42 female) involuntarily hospitalized psychiatric patients in the province of Ontario, were examined. An attempt was made to test the hypothesis that recorded descriptions of symptomatology in committed patients, i.e., at the time of first admission, would be more congruent with the prevailing female gender role expectations if the person were male, and more congruent with the prevailing male stereotype if the

patient were female. This hypothesis was based, as in Rosenfield's (1982) study, on the assumption that commitment is one parameter which reflects the seriousness with which gender role-incongruent behaviour ("deviant deviance") is viewed by society. The above hypothesis was examined by comparing the certificate information for male and female patients, and by devising therein a measure of the gender role identity of this information. Eighty-four certificates were available, in which the sex of the committed person could be determined. These documents, which had been analyzed for other purposes in several previous studies (e.g., Page, 1980, 1981; Page & Firth, 1979) had been provided from clinical records in two Ontario psychiatric hospitals, and had been originally sampled in a random fashion from then current patient files. Each certificate, as described in detail in the above references, consisted of a point-form summary of patient characteristics or behaviours believed by the committing physician (almost always a male) to constitute the psychiatric rationale for the commitment. A measure of the extent to which the overall symptomatology recorded for each patient was perceived as characteristic of the male, or the female, gender role was first developed, by extracting from the certificate entries an exhaustive set of 24 descriptive categories (see Page, 1980, 1981, 1985). Any certificate entry (e.g., "drinks heavily," "continually depressed," etc.) could thus be represented exclusively by one such category. Sixty-seven advanced undergraduate students at the University of Windsor were then presented with the list of descriptive categories and assigned to each a gender role score, using a 7-point Likert scale, according to whether the category was perceived to be more descriptive of a "typical male" or "typical female" problem. Results indicated that the behavioural categories themselves, as a group, showed little tendency to be seen as more

masculine or feminine, since their mean overall gender role score was 3.86 on the 7-point continuum. The mean gender role scores were indeed consistent with current sexual stereotypes, i.e., categories rated as more "feminine" included traits such as overtalkativeness, anxiety, or depression, whereas "male" categories included threatening serious harm with a weapon, alcohol abuse, and so on. The overall symptomatology for each patient (certificate) was then assigned an overall gender identity score, by averaging the mean gender role scores, determined as above, which were found for each separate certificate entry. A certificate bearing five entries, for example, would be assigned a gender identity score which was the average of the mean values of "maleness" or "femaleness" assigned by the 67 judges to the five behavioural categories representing those items. A t-test, with actual patient sex as the independent variable and gender identity scores as the dependent variable, indicated that, for committed male patients, the recorded symptomatology was in fact significantly more congruent with the female gender role stereotype, whereas the symptoms of female patients were significantly more characteristic of the male gender role stereotype. Such results thus support and extend those of Rosenfield (1982), i.e., it would thus appear less serious (and less likely to precipitate hospitalization) when a person's misbehaviour is consistent with prevailing gender role expectations. These results do not negate the common association of males and females with certain types of disorders. They do indicate however that "deviant" deviance, in which symptomatology contradicts traditionally expected forms of male and female behaviour, is viewed more seriously than when the same behaviour occurs in someone of the "appropriate" sex. In fact, it may be that the process of commitment may be seen as most appropriate in cases where the usual means of

treating traditionally male and female problems are not or cannot be employed, or where these means seem inadequate or inappropriate in view of the behaviour displayed. Most cases of male aggressive or antisocial disorder, for example, are handled almost entirely in the criminal justice system (Spitzer, Skodol, Gibbon, & Williams, 1983), while females remain overrepresented in treatment via psychotherapy or drugs (Greenglass, 1982; Hyde, 1985; Rosenfield, 1982).

Summary and Concluding Comments

The above research, together with that of Rosenfield (1982), appears to support Chesler's (1973) early claim that females tend to be judged as maladjusted or "sick" when showing gender role-incongruent behaviour. Referring to "neurotic" or "self-destructive" females who show male propensities such as an uncontrollable temper, use of foul language, or use of alcohol, etc., Chesler thus held that "If such 'male' behaviour is 'neurotic' or 'self-destructive,' then it should be seen as such for both sexes" (1972, p. 70). In emphasizing the situation of women in the late 1960s, Chesler's book predated currently available evidence that gender role-incongruent behaviour appears to be viewed as more serious when found in the male. Results of the above studies are nevertheless entirely consistent with the Broverman et al. (1970) results and also lend empirical support to the theme, mentioned previously, that life events affecting males are judged as more important than events affecting females (Schaef, 1981) or, stated differently, that masculinity is seen as more important and as closer to personhood than is femininity (Broverman, et al. 1972). Some specific results from three of the above-mentioned studies, in which it was possible to evaluate the perceived seriousness of male versus female gender role nonconformity (i.e., DeRose & Page, 1985; Page & Yee, 1985; Waisberg, 1984) thus found that:

1. "Male" disorders were seen as more serious than female disorders.

2. It was judged as more serious for a male to display "female" symptoms, especially those of depression, than for females to display "male" symptoms.

3. Deviation from heterosexuality, while judged negatively in general, was seen as more serious for males. Page & Yee found, for example, that lesbians were seen significantly more negatively than were "normal, healthy adults" on 11 scales, but that male homosexuals were significantly different from "normal, healthy adults," and in a negative direction, on 26 scales. Also, these ratings showed that the Broverman scale profile for "homosexual adult" was virtually identical to that for "homosexual male." Thus, gender role nonconformity, at least in the sexual sphere, was seen as more serious for males, implying a general perception that it is indeed more important for males to be "normal" males than for females to be "normal" females. Moreover, the term "adult" was assumed to imply masculinity.

4. Male suicides were generally perceived as of greater import than those of females (DeRose & Page) and as less likely to be rooted in emotionality, psychological weakness, or emotional maladjustment. Suicide attempts were less likely to be seen as serious or lethal when carried out by a female. While Broverman et al. found that "male" characteristics such as heroism, daring, and sensation-seeking were seen by clinicians as desirable, DeRose & Page found that females were seen as less likely to commit "heroic" suicide, and that engaging in a dangerous sport, for example, was likely to be seen as expressing an unconscious wish to die, i.e., if the target person was female. Interestingly, the SOQ item "Suicides among young males/females (e.g., college students) are particularly puzzling since they have everything to live for"

was endorsed to asignificantly greater extent when referring to a male target person. Also, th item "Suicide rates for males/females are a good indicator of the stability f a nation; that is, the more male/female suicides, the more problems a nationis facing" was endorsed significantly more often when referring to a mae.

The weight ofthis recent evidence does not support Chesler's (1973, p. 118) emphasis upo gender role nonconformity as particularly serious for females. It doeshowever affirm once more the essential validity of the original Broverma et al. study. Social and clinical judgements do appear to be affected not oly by the seriousness of the unacceptable behaviour but also by the degree of congruity with prevailing gender role stereotypes. The trend for this to applymore strongly to male nonconformity appears also to support the claims of Broverman et al., and others, that females tend to be seen as by "nature" less than mentally healthy, and as persons in whom maladjustment is considered intrinsic and thus less problematic or important.

Obviously, much additional research on male and female gender role incongruence is required. In this task, opinion is somewhat divided as to the relative merits o' "analogue" studies, using abstract tasks such as written case histories or vigniettes, versus more naturalistic or behavioural studies of "real" clinician activities. Although future behavioural studies are required, recent analogue studies have also been valuable in reaffirming and elaborating the essential "male as norm" findings of Broverman et al. Smyth and McFarlane (1985), for example, using samples of psychiatrists and psychologists to which the Broverman scale items were administered, found that level of masculinity was again portrayed as a "health" concept, and that "healthy adults" were perceived as more masculine than feminine. Lapp and

Pihl (1985), in another analogue study, have also shown that such biases may indeed affect clinical decisions, especially when taking into account the attitudes, sex, and gender role orientation of the perceiver or evaluator. In their study, judges who were themselves either masculine-typed, feminine-typed, or androgynous, made various judgements about the attractiveness and degree of disturbance shown by videotaped male and female clients. The clients' behaviour, in turn, was either masculine or feminine-typed. Male evaluators made generally less favourable judgements about gender role incongruent behaviour than did female evaluators--a trend also shown by the male clinicians in the Smyth & McFarlane (1985) study. Feminine-typed evaluators found males and masculine-typed clients of both sexes more attractive than females or feminine-typed clients of either sex. Masculine-typed evaluators showed the least sympathy for feminine-typed clients, although they viewed the masculine-typed female client quite unfavourably. Androgynous evaluators, especially females, were the most tolerant of gender role incongruence.

Lastly, it is noted that no evidence exists in support of the view that greater adherence to gender role stereotypes in any way assures or enhances one's personal adjustment (Lips & Colwill, 1978). It is noted also, despite a presumably greater awareness of gender-related biases among clinical professionals (Greenglass, 1982), and the generally positive reaction to the concept of androgyny, that the perception of more positive health or adjustment reflected in the studies cited above was related ultimately to a client's deviation from, and not adherence to, androgynous behaviour.

Quite apart from existing research, however, the issue remains as to whether the androgyny concept (Bem, 197 can or should serve as a model of

mental health or personal adjustment. Androgyny has been heralded as an antidote to the rigidity of sex role stereotyping since it promotes an "ideal" combination of stereotypically male and female characteristics within the same person. The concept of androgyny has drawn criticism however; for example, on the grounds that it remains a heavily evaluative concept, in effect another sex role stereotype, in which the traditional notions of masculinity and femin*in*ity are retained (maybe even promoted) and in which their credibility as valid concepts with which to evaluate or describe behaviour remains unquestioned. These criticisms have been articulated forcefully by Stark-Adamec, Graham, & Pyke (1980) and elucidated further by Pyke (1982). These authors in fact wish to leave androgyny behind. They proceed to build the case that society (including psychologists) should now attempt to foster "sex role transcendence," in which sex-based evaluative concepts and biases would be absent. In like spirit, Doyle thus labels "gender role transcendency" as the "research concept of the eighties and beyond" (1985, p. 359). In light of the recent studies described above, the goal of sex role transcendence, if desirable, conceivable, and possible, appears unlikely to come to fruition with the present generation of North American clinicians. Many professionals, for example, seem generally to endorse the subsidiary concept of androgyny, at least as an abstract egalitarian principle, but do not necessarily act accordingly when making specific evaluative judgements about gender-role incongruent behavior in clients.

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